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IN THE
Supreme Court of the United States
OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners,
v.
TRAVELERS INSURANCE CO., *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
Petitioners,
v.
TRAVELERS INSURANCE CO., *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK,
Petitioners,
v.
TRAVELERS INSURANCE CO., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF *AMICUS CURIAE* FOR THE INTERNATIONAL FOUNDATION OF EMPLOYEE BENEFIT PLANS IN SUPPORT OF RESPONDENTS

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BRIEF *AMICUS CURIAE* FOR THE INTERNATIONAL FOUNDATION OF EMPLOYEE BENEFIT PLANS IN SUPPORT OF RESPONDENTS

The International Foundation of Employee Benefit Plans ("Foundation") submits this brief *amicus curiae*, pursuant to Rule 37 of the Rules of this Court, with the consent of Petitioners and Respondents. Their letters of consent have been filed with the Clerk of the Court.

INTEREST OF *AMICUS CURIAE*

The Foundation is a nonprofit association organized and operated under § 501(c)(3) of the Internal Revenue Code. Its mission is to provide employee benefits education through a broad range of information services, publications, and educational programs. Total membership consists of 34,000 individuals representing more than 7,500 trust funds, corporations, public employee funds and professional firms throughout the United States and Canada.

The Foundation traces its origins to the mid-1950s with the creation of the National Conference of Health and Welfare Plans. For almost a decade the organization continued to thrive and that growth was reflected in the new name that was chosen for the organization in 1964—the National Foundation of Health, Welfare and Pension Plans. In 1974, regulation of employee benefit plans was federalized with the passage of the Employee Retirement Income Security Act of 1974 ("ERISA").[1] That same year, the Foundation's present name was adopted to more accurately reflect the Foundation's scope and character.

The sole purpose of the Foundation is to provide education in the employee benefits field. To achieve this purpose, it presents a yearly program of conferences, institutes, and seminars to approximately 14,000 benefit plan representatives. The Foundation also publishes numerous books, magazines, journals, and booklets of interest to those in the employee benefits community and conducts extensive research and surveys on employee benefit plan

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[1] Pub. L. No. 93-406, 88 Stat. 832 (1974) (codified as amended at 29 U.S.C. §§ 1001-1461 (1988)).

matters. The Foundation promotes no particular point of view in any of its educational activities. The only emphasis is on the education of those who serve employee benefit plans so that they might be more effective on behalf of the millions of employees and members of their families who are plan beneficiaries.

Consistent with its educational mission, the Foundation is filing this brief to bring to the Court's attention the results of its research on the subject of ERISA preemption and the consequences for employee welfare benefit plans if federal law did not preempt state regulation impacting them such as the system of surcharges at issue in this case. It leaves to the parties and other *amici* any in-depth discussion of the legal merits of that controversy.

SUMMARY OF ARGUMENT

The overwhelming majority of nonelderly Americans today obtain health care coverage through ERISA-covered welfare benefit plans, and these plans are critically important to their security and well-being. In enacting ERISA to protect the interests of participants and beneficiaries in these plans, Congress expressly intended to make employee benefit plan regulation a "matter of exclusive federal concern."[2] That regulatory scheme, while comprehensive in character, conciously leaves the basic decisions of whether to establish a plan, the design of those plans and the level of benefits that those plans will provide to the private sector.

Given its reliance on the private sector to provide health coverage to employees and their families, Congress was concerned that its regulatory efforts not be counterproductive and serve as a disincentive to plan formation and growth. Accordingly, it minimized regulation of employee benefit plans to avoid encouraging "employers to

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[2] *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981).

respond . . . by decreasing benefits under existing plans or slowing the rate of formation of new plans." [3] ERISA's preemption of state law—ERISA's "crowning achievement"—was a key component of this effort, since it frees employee benefit plans from costly and intrusive state regulation that not only could conflict with the federal scheme, but also vary from state to state and thereby create additional inefficiencies and burdens for plans that operate across state lines.

Despite Congress's efforts to create an atmosphere in which employee benefit plans could thrive, the private employee welfare benefit plan system is under greater threat today than ever before. The spiraling cost of health care is a matter of public record. While plan sponsors have responded to these increases with innovative cost containment techniques, these efforts have been only partially successful. As a result, plan sponsors often have been left with little choice but to increase employee contributions for coverage, reduce benefits, or eliminate benefit programs entirely.

The entry of the states, such as New York, into this area through efforts to expand coverage or transfer the cost of otherwise uncompensated care to the private welfare plan system can only exacerbate the problems faced by plan sponors. A system of surcharges, such as that chosen by New York, has the inevitable consequence of increasing plan costs. Moreover, by creating incentives to provide benefits in a particular way, these state efforts not only limit the flexibility of plan sponsors to design a program tailored to their participants' circumstances, but also can negate the effectiveness of other measures undertaken by plans to control their costs.

The intrusion of states into this area also raises the very specter of patchwork regulation that ERISA's preemption provisions were designed to avoid. If one state has the authority to regulate in this area, others presum-

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[3] H.R. Rep. No. 807, 93d Cong., 2d Sess. 15 (1975).

ably can follow suit. There can be no assurance that, in responding to the problems in the health care field, states will address the same concerns, much less that they will do so in the same way.

Indeed, this Court need look no further than the circumstances surrounding this case for a graphic illustration of the differing regulation that might result. A plan located in New York easily could cover participants in New Jersey and Connecticut, as well as New Yorkers. Each of these states has adopted legislation addressing aspects of the uncompensated care problem faced by hospitals. However, the means selected by each of them is different, thereby creating their own set of costs and administrative burdens for employee benefit plans operating within those jurisdictions.

While state laws like the scheme here at issue pose problems for all plans, they particularly disadvantage multiemployer welfare benefit plans, commonly known as Taft-Hartley funds. These plans, which cover approximately 20 million Americans today, are creatures of the collective bargaining process and provide portability of benefits to their participants, *i.e.*, employees can move among contributing employers and not lose coverage. They are administered by a joint board of trustees, half of whom are appointed by management and half of whom are appointed by labor. The assets of these plans are held in trust and their funding is principally provided by employer contributions at rates negotiated in collective bargaining and which generally reflect the economic climate of the industry covered by the plan.

State laws such as those here at issue have a number of dramatic impacts on participants in these plans. Because the rate of negotiated contributions generally is fixed for the duration of the collective bargaining agreement, trustees of multiemployer plans lack the flexibility possessed by other plan sponsors to respond to changing economic circumstances. Thus, benefit cuts or adjust-

ments for participants in these plans are often inevitable when health care costs increase unexpectedly during the contract's term.

Moreover, while employer contributions fund these programs, those contributions are, in a real sense, a substitute for wages. Thus, the cost of financing these programs is borne primarily by the active workforce out of what would otherwise constitute current compensation. Nonetheless, Taft-Hartley funds traditionally have extended coverage to non-working participants, such as retirees. The burden on active employees of the cost-sharing already inherent in these funds can only be heightened by state regulations that have the effect of diverting the plan's assets away for other purposes. A likely consequence is the reduction or elimination of coverage for non-working participants under these plans. Thus, the additional burdens imposed by state efforts such as those here at issue may well lead to an increase in the ranks of the uninsured.

ARGUMENT

In New York, any patient entering a hospital is assigned to a "diagnosis-related group" ("DRG"), based on his symptoms and the expected cost of treatment. The hospital's charges for the patient's care are based on the DRG, not the actual cost of treatment. The base DRG rate includes a component intended to help defray part of hospitals' losses in providing uncompensated care. The DRG amount charged to a particular patient is then increased by a "payor factor," depending upon the type of health care coverage the patient has. This results in a "differential" in the charges, depending upon the nature of the patient's health care coverage. *See Travelers Ins. Co. v. Cuomo,* 14 F.3d 708, 712 (2d Cir. 1993).

Three different "surcharges" are imposed. A 13 percent surcharge is added to the DRG rate for patients covered

by any form of health plan (including self-funded ERISA plans) other than the Blues, an HMO, or government insurance such as Medicaid. N.Y. Pub. Health Law § 2807-c(1)(b). This surcharge is retained by the hospital and, among other things, helps satisfy the costs of uncompensated care. Patients covered by commercial insurers are charged an additional surcharge in the amount of 11 percent. *Id.* § 2807-c(11)(i).[4] The proceeds of the 11 percent surcharge are paid into a statewide pool, which is then deposited into the state's general fund. Both of these charges have the effect of encouraging employers and ERISA plans to subscribe to the Blues. *Travelers Ins. Co.*, 14 F.3d at 712. The Blues are favored by the legislative scheme because they provide open enrollment and community rating, both of which make health insurance more widely available, albeit at additional cost.[5] HMOs are assessed a surcharge of up to 9 percent depending on the extent to which they enroll Medicaid recipients.

I. STATE LAWS LIKE NEW YORK'S HOSPITAL REIMBURSEMENT SCHEME COULD RESULT IN A REDUCTION IN THE LEVEL OF BENEFITS PROVIDED UNDER EMPLOYEE WELFARE BENEFIT PLANS

In enacting ERISA, Congress chose to preserve the voluntary nature of private employee benefit plans. ERISA neither requires employers or employee organizations to maintain any benefit plans nor prescribes the level of benefits that must be provided by the plans they establish. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. at 511 ("private parties, not the Government, control the level of benefits"). Rather, ERISA's provisions were

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[4] The 11 percent surcharge on commercial insurers has expired in accordance with its terms.

[5] "Open enrollment" permits any person to obtain coverage regardless of physical condition, age, or prior illness. "Community rating" sets premiums based on the experience of an entire pool of risks. *See* Brief for Petitioners Mario M. Cuomo, *et al.* at 3 n.2.

designed to ensure that the plans that are adopted treat employees fairly and are administered properly and that the assets of these plans are used for "the exclusive purpose of: (i) providing benefits to participants and their beneficiaries; and (ii) defraying reasonable costs of administering the plan . . . ." 29 U.S.C. 1104(a)(1)(A).

Moreover, Congress was aware that overregulation of the field could be counterproductive; it could result in the adoption of fewer and less generous benefit plans. Congress's goal was to protect the interests of plan participants without burdening plans so heavily that "employers respond . . . by decreasing benefits under existing plans or slowing the rate of formation of new plans." H.R. Rep. No. 807, 93d Cong., 2d Sess. 15 (1974).

ERISA's preemption provision is a major component of the statutory scheme. With narrow exceptions, ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). This preemption provision is referred to in the legislative history as the statute's "crowning achievement." 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent). It has been repeatedly recognized as both "conspicuous for its breadth," *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990), and "deliberately expansive." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987).[6]

In its numerous decisions addressing ERISA preemption, this Court has recognized that the intrusion of the states into the regulation of employee benefit plans could cause inefficiencies that result in harm to plan participants. "A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to

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[6] *See also Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985) (noting the "broad scope" of ERISA's preemption provision); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983) ("the breadth of [§ 1144's] preemptive reach is apparent from its language").

reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). Moreover, "the inefficiencies created [by the need to comply with conflicting directives among the States or between the States and the Federal Government] could work to the detriment of plan beneficiaries." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). ERISA's preemption of state law eliminates this threat to employee benefit plans.[7]

This case involves a subset of employee benefit plans—"employee benefit welfare plans" or "welfare plans." Under the statutory definition, welfare plans include plans that provide "for . . . participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits." 29 U.S.C. § 1002(1). According to a recent study, employer-sponsored welfare plans provide health insurance coverage for more than 150 million Americans. Employee Benefits Research Institute, *Issue Brief Number 150* at 20 (June 1994).

ERISA welfare plans today provide health care coverage for an overwhelming majority of non-elderly Americans. *Travelers Ins. Co.*, 14 F.3d at 711. Unlike pension plans, however, there are no ERISA constraints on the sponsors of these plans from discontinuing future coverage if the regulatory atmosphere surrounding them becomes too burdensome and costly.[8] Such plans are not

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[7] Of course, Congress retains the right to correct any potential abusive situations that may result from the elimination of state authority in this area. For example, subsequent to ERISA's passage, Congress amended its preemption provisions to extend states certain regulatory authority over so-called "multiple employer welfare arrangements." *See* 29 U.S.C. § 1144(b)(6) (added by Pub. L. No. 97-473, Title III, § 302, 96 Stat. 2612-13 (1983)).

[8] It is noteworthy that the number of defined benefit pension plans, which subject employers to greater economic risk and are subject to more extensive regulation than other types of pension plans, has declined significantly in recent years. 20 *Pension Re-*

required to grant participants vested rights in future health care protection based on prior years of employment. Benefits earned under pension plans for prior services must become vested—"non-forfeitable"—as provided in the plan document or under ERISA's minimum vesting standards. 29 U.S.C. § 1053. But the sponsors of welfare plans have the freedom to reduce or terminate health care benefits, provided only that the plan document permits such amendment or termination. 29 U.S.C. § 1051(1); *see, e.g., Adams v. Avondale Indus., Inc.*, 905 F.2d 943, 947 (6th Cir.), *cert. denied*, 498 U.S. 984 (1990).

The continued escalation in health care costs and the enormous burden it has placed on the Nation's private employee benefit plan system are matters of public record. According to a General Accounting Office study, in 1990 alone American businesses spent approximately $186 billion in providing health care benefits to their employees. U.S. General Accounting Office, *Employer-Based Health Insurance* (GAO/HRD-92-125) at 3 (1992) ("*GAO Report*"). And the average cost per employee of a comprehensive health insurance plan increased by 23.3 percent beween 1990 and 1992. *Issue Brief Number 150* at 21. The impact of these cost increases can be devastating for the private sector:

> Rapidly increasing business outlays for group health insurance are a serious problem for all firms, but some firms have experienced severe hardships as their costs have escalated to levels that threaten the competitiveness of the firm. Firms in declining industries with aging work forces are faced with health insurance premiums that exacerbate their competitive problems. Such firms not only have to deal with the general rise in health care costs, but also are hit by further increases which reflect the poor health experi-

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porter (Bureau of Nat'l Affairs), at 2495 (Nov. 29, 1993) (noting that the number of such plans has declined by approximately 20,000 or by 14.6 percent from 1989 to 1990).

> ence of their aging work force. Small firms are even more vulnerable since poor health experience of one or two workers can threaten their capacity to obtain affordable health insurance coverage.

GAO Report at 12.

Plan sponsors increasingly have responded to higher costs by reducing or eliminating benefits:

> Differences among firms in financial condition and competitive environment generate a variety of employer strategies to control health cost growth or to reduce overall health spending. The benefit plan design, over which the employer has the most control, is generally the first factor a firm will alter to control rising costs. Such plan changes can include some combination of eliminating or limiting family coverage, retiree coverage, or covered services.

GAO Report at 10. Other cost containing measures that have been adopted include shifting costs to the employees in the form of higher deductibles, co-payments or higher contributions toward premiums; limiting coverage for certain conditions;[9] and completely eliminating coverage. *Id.* at 10-11. The study concludes,

> Competition among businesses has caused some to eliminate or reduce health benefits for employees, dependents, or retirees. Rising health costs have also caused employers to attempt to shift more of the costs of care to employees through higher premiums, deductibles, and copayments.

Id. at 13.

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[9] *See McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir. 1991) (upholding plan amendment that drastically reduced benefits for AIDS patients shortly after a participant developed AIDS), *cert. denied*, 113 S. Ct. 482 (1992). *See also* Marko J. Mrkonich & Gail A. Engstrom, *Employer-Sponsored Health Plans and Experimental Medical Treatments: Life and Death Cost/Benefit Decisions*, Employee Benefits J., June 1994, at 4-5.

State intrusion into this area can only aggravate the problems already plaguing plan sponsors. For example, the system of surcharges imposed by New York presents them with little more than a Hobson's choice. They can either provide coverage through the Blues (at a higher cost) or they can pay the state-imposed surcharges. Under either alternative, the cost of providing health care coverage is increased. Under either alternative, those who voluntarily provide health care coverage for their workers and dependents are forced to bear the cost of providing coverage to the uninsured, including employees of employers who do not provide coverage.[10] Moreover, because the plan's costs are increased by the experience of those outside the plan, the success of any cost-containment measures implemented with respect to the plan's own participants and beneficiaries may be negated. *Id.* at 40-41.

State regulatory efforts such as that here at issue also raise the specter of patchwork state regulation that ERISA was intended to eliminate. Many ERISA plans cover employees across state lines. Multiemployer plans, established through collective bargaining between industry and labor, are especially likely to cover participants in several different states. If one state is free to legislate in these areas, other states also must have this authority. However, there can be no assurance that each state will address the same concerns in responding to health care problem, much less that they will do so in the same manner. The cost of providing benefits for participants in the same plan could be markedly different if states are free to address these issues in varying ways.

This prospect of differing state regulatory schemes is not idle speculation, as the circumstances surrounding this case illustrate. A plan based in New York City would

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[10] The GAO study indicated that in 1990, nearly 50 percent of the Nation's uninsured were employed on either a full or part-time basis, while approximately an additional 33 percent of the uninsured were non-working dependents of such employees. *GAO Report* at 23.

almost certainly cover participants who live in the neighboring states of New Jersey and Connecticut, as well as New Yorkers. Each of these states has responded to the problems of uncompensated care faced by hospitals in a different manner. New York, of course, has chosen to regulate hospital reimbursement rates through a DRG system involving surcharges and incentives for the Blues. New Jersey likewise has adopted a system using DRG rates, surcharges, and incentives to insure with the Blues, but its system differs in many respects from that employed in New York. *See United Wire, Metal, & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d 1179 3d Cir. 1993), *cert. denied*, 114 S. Ct. 382 (1993). Connecticut, on the other hand, has turned to a system of taxes and assessments on hospital charges, without any inducements to use the Blues. *New England Health Care Union District 1199 v. Mount Sinai Hospital*, 846 F. Supp. 190 (D. Conn. 1994) (Connecticut's Uncompensated Care Pool Act is preempted by ERISA). Should the Court conclude that this category of state regulation survives ERISA preemption, such conflicts can only become more and more widespread.[11]

To the extent that systems such as that adopted by New York are designed to make health care coverage available to the uninsured, their underlying social policy is laudable. However, rather than on the public at large, the costs of these efforts inevitably fall primarily on ERISA-covered plans. *See United Wire*, 995 F.2d at 1199 (Nygaard, J., dissenting) (noting that New Jersey's surcharge system "was designed with ERISA funds in mind"); *New England Health Care*, 846 F. Supp. at 195 (suggesting that as much as 70 percent of the funding for Connecticut's Un-

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[11] *See also NYSA-ILA Medical & Clinical Services Fund v. Axelrod*, 27 F.3d 823 (2d Cir. 1994) (an assessment on hospital gross receipts is preempted as applied to medical facility owned by an ERISA plan); *Boyle v. Anderson*, 849 F. Supp. 1307 (D. Minn. 1994) (a 2 percent tax on gross receipts of health care providers is not preempted by ERISA).

compensated Care Pool Act came from ERISA plans). Thus, whether by design or not, these state efforts have the effect of diverting an employee benefit plan's assets away from their congressionally-mandated purpose—to provide benefits to the plan's participants and beneficiaries.

Ironically, by eroding a plan's ability to provide coverage to individuals who would otherwise fall within the ranks of the under- or uninsured, these state efforts may exacerbate, rather than eliminate, the very problems they are designed to address. Any reduction in or elimination of health care benefits under ERISA plans resulting from increased costs and administrative burdens would simply mean that previously protected employees or their family members may join the ranks of the unprotected. Of course, a state could respond by increasing its surcharges, but that in turn could provoke a further downward spiral in ERISA plan benefits and coverage.

II. THE SYSTEM OF SURCHARGES AT ISSUE IN THIS CASE CREATES INCENTIVES THAT INTERFERE WITH FLEXIBILITY IN PLAN STRUCTURE

The surcharges at issue in this case limit the flexibility of plans and plan sponsors in their efforts to control health care costs and provide the most appropriate form of coverage to the participants of their plans. New York may view the Blues' practices of open enrollment and community rating as socially desirable (*see* Brief for Petitioners Mario M. Cuomo, *et al.* at 3), but ERISA recognizes no such value judgments. Rather, ERISA's focus, and, in particular, that of its fiduciary responsibility provisions, is on the plan's own participants and beneficiaries and their benefit needs.

ERISA welfare plans can provide coverage in a number of ways. Plans sponsored by smaller firms might provide coverage through third parties—commercial insurers, health maintenance organizations (HMO's), or the Blues. Larger plans, on the other hand, might choose to "self-

fund" for health care—to provide benefits from an employer's general assets or from a trust fund from which benefits are paid directly to the health care provider.[12]

ERISA deliberately leaves the choice from among these various alternatives to the plan sponsor. It provides no incentives designed to encourage the selection of any particular mechanism. The New York surcharges, however, are designed to encourage ERISA plans to move away from commercial insurers or self-funding and into the Blues. As the court of appeals noted, "the [13 percent] differential was meant to level [the] playing field for the Blues in their competition with commercial insurers." 14 F.3d at 712 (internal quotations omitted). Similarly, the 11 percent surcharge has the effect of "increas[ing] commercial insurers' costs of providing health care, thus making them less competitive with the Blues." *Id.* These incentives to choose the Blues in preference to other methods limit the flexibility of plan sponsors to provide health care coverage for their participants and beneficiaries through what otherwise would be more cost-effective means.

Incentives such as these also pose potential conflicts with ERISA's fiduciary responsibility provisions, particularly where they implicate the assets of multiemployer trust funds or self-funded plans. The fiduciary duty of undivided loyalty to participants and beneficiaries lies at the heart of ERISA's rules of fiduciary conduct. 29 U.S.C. §§ 1103(c)(1), 1104(a)(1)(A). Fiduciaries are required to perform their duties with an "eye single" to the interests of the plan's participants and beneficiaries.

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[12] ERISA expressly permits the states to regulate the business of insurance. 29 U.S.C. § 1144(b)(2)(A). Thus, plans that provide coverage through the purchase of insurance policies are subject to limited regulation by the states. Self-funded plans, however, are exempt from even this limited sphere of state regulation. Perhaps for this reason, self-funding is becoming more attractive as costs escalate. *See GAO Report* at 11 (noting that firms can reduce costs by shifting to a self-funded plan).

Donovan v. Bierwirth, 680 F.2d 263, 271 (2d Cir.), *cert. denied*, 459 U.S. 1069 (1982). Moreover, they are directed to use the plan's assets for the "exclusive purpose" of providing benefits to the plan's participants and beneficiaries. *See* 29 U.S.C. § 1104(a)(1)(A).[13] A state-created incentive to select one form of coverage over another not only could interfere with plan fiduciaries' duty to base such decisions on the circumstances and needs of the particular plan's participants, but could also result in the diversion of that plan's assets for other than their intended benefit purposes.

III. THE SURCHARGES IMPOSED BY THE STATE OF NEW YORK PRESENT SPECIAL DIFFICULTIES FOR MULTIEMPLOYER WELFARE PLANS

The Foundation's membership includes multiemployer as well as single-employer welfare plans. Multiemployer welfare plans—commonly known as Taft-Hartley funds—are the products of collective bargaining between union and industry representatives. While relatively small in number,[14] it was estimated that in 1992 such plans covered some 20 million or more participants and their beneficiaries. *Multiemployer Health and Welfare Plan Fact Sheet for Congressional Briefing on Basics of Employment Based Health Benefits* at 1 (1992) ("*Fact Sheet*"). Benefits provided under multiemployer welfare plans are portable—"workers may move freely among employers contributing to the same trust, maintaining full health care

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[13] The Department of Labor long has taken the position that fiduciaries must first satisfy their basic fiduciary duties, and, in particular, their prudence obligation, before taking "social" considerations into account in investing the plan's assets. *See* ERISA Interpretive Bulletin 94-1, *published in* 59 Fed. Reg. 32606 (June 23, 1994).

[14] According to Department of Labor statistics, in 1987 approximately 4,500 of the 85,000 ERISA-covered welfare plans were multiemployer plans. U.S. Dept. of Labor, *ERISA Enforcement Strategy Implementation Plan in Employee Benefit Issues 1993* at 386.

benefits." *Id.* at 2. Industries that provide coverage through multiemployer welfare plans include building and construction, clothing, transportation, service, retail, maritime, printing, and food. *Id.*

Multiemployer plans are created pursuant to collective bargaining agreements and are administered by a joint board of trustees, which is made up of equal numbers of union and management representatives pursuant to the Taft-Hartley Act. 29 U.S.C. §§ 186(c), 1002(16)(B). Active employees thus participate in the design and functioning of their welfare plans in two ways—through the collective bargaining process and by appointing members to the board of trustees. This participation by employees perhaps explains why multiemployer plans typically provide health care benefits for many who otherwise would be uninsured, in addition to active workers.[15]

Taft-Hartley plans, by law, must hold their assets in trust. 29 U.S.C. §§ 186(c), 1103. These plans are funded through employer contributions and investment earnings thereon. Contribution rates are established in collective bargaining and generally reflect the economic state of the industry covered by the plan. These contribution rates usually cannot be increased during the term of the collective bargaining agreement. *Fact Sheet* at 1.[16]

While these contributions are made by employers, Taft-Hartley funds, in a very real sense, are financed by active workers; employer contributions negotiated in collective bargaining are substitute wages for labor performed.[17]

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[15] *See Retiree Healthcare Coverage Increases Among Multiemployer Plans*, vol. 70, No. 4 HRFocus at 10 (Apr. 1993) (only 32 percent of surveyed plans excluded coverage for retirees); National Coordinating Committee for Multiemployer Plans, *Taft-Hartley, Multiemployer Health & Welfare Plans* at 1-2 (Apr. 1994).

[16] Research collected by the Foundation indicates that most collective bargaining agreements (74 percent) have three-year terms.

[17] According to one study, benefit costs averaged 40 percent of employers' payroll in 1992. *See Employers' Benefit Costs Averaged*

The active workers thus pay for their own coverage *and* for benefits extended to nonactive plan participants. The burden on active workers has increased dramatically in recent years as recession led to substantial lay-offs and early retirements among workers in many unionized industries. *See Taft-Hartley, Multiemployer Health & Welfare Plans* at 2 ("Fewer jobs to generate contributions means less income to our plans, even as benefit claims increase."). In other words, a greater financial burden is borne by a smaller number of workers.

Because the employers' contribution level is set for the duration of the agreement, a Taft-Hartley plan's board of trustees is called upon to establish and administer a benefit program within the confines of the budgeted amount. *See generally* Marc Gertner, *Trustees Handbook* 145-78 (4th ed. 1990). When faced with increased costs during a contract's term, multiemployer plan trustees are forced to either reduce benefits or collect co-payments from employees. Upon expiration and renegotiation of the collective bargaining agreement, employer contribution levels can be increased but only by shifting a greater percentage of total compensation away from wages and other important benefit programs. Either way, the active workers pay the costs.

Surcharge systems like that adopted by New York impose additional burdens on these active employees. These surcharges have the effect both of increasing the costs of these plans and shifting part of the cost of providing care for the uninsured and underinsured onto them. As noted above, however, the active employees covered by multiemployer plans not only bear the cost of their own coverage, but also finance health care benefits for retirees and unemployed plan participants, who otherwise would be among the uninsured. As a result, cost-sharing already inheres in the multiemployer plan system, and, of

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40.2% of Payroll in 1992, Human Resources Management: Ideas and Trends in Personnel at 86 (Mar. 3, 1994).

key importance to the value of these plans has been the ability of the bargaining parties to custom-tailor plan features to the particular needs of a given industry and their own plan participants. To allow state programs to divert the assets of those plans away from the needs of their own plan participants could result in cost adjustments by plans, and lead to reductions in coverage for non-active participants, again adding to the ranks of the uninsured.

CONCLUSION

Employee benefit plans are designed and administered with one purpose in mind—to provide benefits to their participants and beneficiaries. ERISA's preemption of state law permits them to fulfill this purpose more effectively by freeing them from the burdens of state regulation that could increase their costs and limit their flexibility to respond to the needs of the parties they serve.

Respectfully submitted,

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